MEDICAL INSPECTION OF IMMIGRANTS AT ELLIS ISLAND, 1891-1924

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> The American may profess to admire efficiency at all costs, but one place where he wants his business suit let out at the seams is politics. If he did not want that, if he did not believe that these adjustments were part of the humanizing side of the democratic process, the American might quite quickly fall a victim to the German passion for leaving it all to the expert . . . . Of course, the politician may tell the expert too much, too often, and in tones that make it certain that experts will prefer to work for anybody rather than the United States.
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> D. W. Brogan
> *The American Character*

IN New York Harbor the Statue of Liberty turns her back on Ellis Island, a gesture at once accidental and superb. Between 1892 and 1924 this juxtaposition of hope and rejection described the passage of every immigrant who came to America by steerage. Immigrants, by choosing the United States, also chose to enter history: their individual decisions to enter the New World are recorded in the millions of names listed on ship manifests now in the National Archives. At Ellis Island the self-consciously modern bureaucracy of a young country recorded and sifted the peasantry of the Old World. Ellis Island is not only the story of immigrants, but also the story of the Americans who officially received them. Among these Americans were the surgeons of the United States Public Health Service,[1] who in 1891 were assigned to the medical inspection of all immigrants entering United States ports. Institution of medical examination did not begin in a vacuum: developments in American science and culture together formed a climate which considered medical examination both acceptable and necessary.

The medical inspection was the first of various hurdles each immigrant had to pass in the bureaucratic maze that was Ellis Island. At the dock, after the first and second class passengers had landed,[2] attendants identified steerage

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passengers by a slip of paper pinned to their clothes indicating the ship manifest on which their names would be found, and put them on barges for Ellis Island where, on landing, other attendants guided them to the main building and made sure that they walked in single file through the door.

Entering the building, they walked toward a young man in a military uniform who peered very hard at them in a systematic observation which began at the feet and traveled up to the face. This young man was a United States Public Health Service physician, and he was at that moment undergoing training in "the best school for physical diagnosis in the world," the Line Inspection at Ellis Island. Immigrants—anxious, excited, and dazed—did not notice that the physician was perhaps equally dazed because he was expected to pick out, in the time it took each man, woman, and child to walk past him, every physical and mental defect which might make the immigrant inadmissible to the United States.

Turning a corner, immigrants came upon another physician, perhaps older than the first, who quickly everted each eyelid to look for trachoma. Physicians marked any immigrant suspected of disease or defect with chalk. It was estimated that a total of six seconds was spent on each immigrant inspected on the "line."[3] Most immigrants went upstairs to the main registry hall, where an anxious wait of several hours usually led to a landing card and America.

For chalkmarked immigrants, the wait was longer. Immigrants in acute distress went to the hospital for treatment. Those who had aroused the attention of the physicians were detained for further examination.

Until 1891, immigration into the United States was under the jurisdiction of the various states, and New York was the largest port of entry, accounting for 80% of all immigration.[4] Federal law in 1891 put immigration under federal control and, for the first time, excluded certain classes, namely "idiots, insane persons, paupers or persons likely to become a public charge, and persons suffering from a loathsome or a dangerous, contagious disease." Medical examination was to assist in identifying the preceding classes. Also excluded were criminals, polygamists, and contract laborers. The list grew longer and longer with succeeding laws passed in 1903, 1907, and 1917, but these additions were largely subclasses of those named in the original Act of 1891.

By establishing medical inspection in 1891, legislators implicitly acknowledged a startling change in United States medicine. Medical America, initially insulated from the early discoveries of Lister and Pasteur by 3,000

miles of ocean, began to awaken slowly to the arguments of the germ theory by the late 1870s. The implausibilities of the germ theory—that invisible animalcules were the cause of so much disease and suffering—were overriden by the almost religious fervor of the generation of American doctors returning from the clinics of Germany and Vienna during the 1870s and 1880s.[5]

Why the germ theory so quickly achieved ascendancy is a question to which there is still no satisfactory explanation.[6] In 1882, the year that Koch isolated the tubercle bacillus, a pillar of the New York medical establishment, Alfred Loomis, peered into a crowded lecture hall and remarked to an appreciative audience, "People say there are bacteria in the air, but I cannot see them." But the 1886 edition of Austin Flint's standard *Practice of Medicine* would contain a chapter on bacteriology by the young W. H. Welch: the germ theory had reached the American medical rank and file.[7]

No segment of American medicine championed the germ theory with such enthusiasm as the surgeons of the United States Public Health Service. German science and American restlessness combined in this small (53 physicians in 1891, 128 in 1910) group of physicians which by 1887 had established one of the earliest research laboratories in the United States, the Hygienic Laboratory.[8] Enlarged each year by the handful of young physicians who had managed to pass the rigorous entrance examinations, the Service, by the last decade of the 19th century, was firmly set in its path of becoming the soldiers of the public health movement.[9]

Until the 1880s, no one group of medical practitioners could claim clear therapeutic superiority over any other, and 19th century Americans chose their cures with as much freedom as they chose their elected officials. Americans guarded their "medical freedom" as jealously as their more traditional freedoms of speech and religion because, somewhat perversely, they regarded the proliferating and contradictory therapeutics of the era as yet another example of free choice in "our own free Republican America."[10]

The combination of the germ theory and the public health movements of the late 1880s portended both the demise of America's era of medical freedom and a steady rise of American medicine in the public esteem. Though improvements in morbidity actually antedated the advances of the germ theory, the time was ripe for public acceptance of a unitary theory of disease and concomitant consolidation of the medical profession.

The first "beneficiaries" of the public health movements of the late 1880s were the urban poor, just as the first nonmilitary group subjected to

compulsory medical inspection in 1891 was made up of European immigrants.[11] Starting with the least powerful members of the population, the public health movement could depend on the equanimity of the public.[12] The necessity for social constraints in the name of public health was explicitly stated by one of the movement's foremost apologists, C.-E. A. Winslow: "The discovery of the possibilities of widespread social organization as a means of controlling disease was one which may almost be placed alongside the discovery of the germ theory of disease itself as a factor in the evolution of the modern public health campaign."[13]

In 1912 the Senate passed a public health bill putting the centralized federal health agency into the hands of the same group of physicians who 20 years before had begun medical inspections at Ellis Island, the surgeons of the Public Health Service. This bill was the death knell of "medical freedom" in America, for the purview of the Public Health Service would no longer be limited to the poor, the foreign, and the very young, but extended in theory to all the citizens of the country. The axioms of the germ theory led inevitably to the corollary of a vulnerability to disease independent of economic or social accident. Infectious diseases, caused by "the most democratic creatures in the world"—germs—made few distinctions between paupers and burghers. No social class would be spared the role of patient.

Resistance to a single state-sanctioned medicine died hard. In 1910 the National League of Medical Freedom successfully blocked federal legislation that "put into power any one system of healing and used the government ... to enforce its theories and opinions upon citizens."[14] The propaganda of the proponents of the public health movement was equally impassioned, and the Public Health Service undertook to teach the public that fighting epidemic disease was as valorous as fighting a foreign enemy. "The medical officers of the Marine Hospital Service," wrote an anonymous Service physician in 1892, "are engaged in functions of the highest importance to the welfare of the country, and frequently at posts of danger from which it is the instinct of human nature to flee in terror."[15] Each annual report of the Surgeon General began with a list of casualties among officers fallen in the performance of their duties. When the Public Health Service officer, Joseph Goldberger, lay seriously ill of yellow fever in 1902, he recited in his delirium the names of the Service officers who had died of yellow fever in previous campaigns.[16] The exuberance of being in the forefront of a new science, the romance of brave acts, and the small size of the corps gave the Public Health Service a peculiar esprit well into the 20th century.

The medical inspection of immigrants would have been inconceivable without public acceptance of medicine's increasing influence. Only the growing prestige of scientific medicine, unprecedented in American history, made such delegation possible. One test of medicine's efficacy in the political arena was at Ellis Island. The 19th century image of medicine as a "body of jealous, quarrelsome men" was too strong in the public mind to vanish overnight without a trace. As late as 1906 a widely circulated handbill issued during the 59th Congress warned lawmakers contemplating additional immigration legislation that "any malevolent or narrow-minded medical inspector ... might be tempted to abuse his power."[17] Clearly, in spite of the medical profession's increasing influence, a sizeable American sentiment rebelled against the delegation of political decisions to physicians.

The number of immigrants debarred from American ports was always very small, but rose slowly between 1891 and 1921. During Ellis Island's busiest years, 1900-1914, deportations fluctuated around 1%. In 1914 a record 2.5% were turned away. Over the years, deportations on medical grounds also rose steadily, and accounted for 57% of all cases in 1913. This increase in medical deportations reflected both increased stringency of medical inspection and expansion of medicine's domain.

During the mid-1890s the Eastern establishment began publicly to express dismay at new immigration from eastern and southern Europe, which after 1896 began to surpass old immigration from northern Europe.[18] In contrast to older immigrants from Germany, Great Britain, and Scandinavia, new immigrants from Russia, Poland, and Italy were perceived as racially different from Americans and incapable of assimilation. The problem confronting restrictionists at the turn of the century was barring all immigrants perceived as undesirable (i.e., not north European), while simultaneously giving a semblance of fairness. It was one thing for Henry James, who visited Ellis Island in 1904, to write of the alien's "monstrous, presumptous interest ... to share in one's supreme relation to one's country," but quite another to express such a sentiment on the statute books. Immigration restriction was not inconsistent with the reform temperament of the Progressive Era, but the grounds on which it was based had to pass criteria of fairness and rationality.[19]

The increase in medical deportations reflected many currents in the intellectual temper of the times, foremost being the Progressive Era's need to justify all public actions on the grounds of science and morality. Medicine's impressment into the cause of immigration restriction was implicit in the first federal law of 1891, and for the next 30 years the immigration restriction movement regarded medical inspection as its most promising tool.

At the Port of New York the medical examination contemplated by the statute of 1891 did not begin auspiciously. While waiting for completion of new buildings at Ellis Island, federal officers resigned themselves to the old and inefficient Barge Office on the Battery because New York State, angered at the federal takeover of immigration, refused to surrender Castle Garden for the purpose. Marine Hospital Service physicians received scarcely greater cooperation from federal officials. There were no rooms at the Barge Office for the medical officers, nor was a launch available.[20]

A further obstacle to the Marine Hospital Service was the technical reading of the word "surgeon."[21] "The term 'surgeon' as it occurs in the law is evidently used in its general sense," wrote a Bureau physician in the Surgeon-General's Annual Report of 1891, "but in the efforts of interested parties to break down the inspection service at the start it was claimed ... that a full surgeon, of which there are but a limited number, must make the examinations."[22] A civil surgeon was appointed after the claim was upheld by the courts. The medical department at Ellis Island remained under the dual authority of the Marine Hospital Service and the Bureau of Immigration until 1903.

Most important, however, New York State authorities refused to turn over quarantine to the Marine Hospital Service, and retained within its jurisdiction typhus, cholera, plague, smallpox, and yellow fever. State monoply of these "germ diseases" had profound and unpredictable reverberations on the medical reception of immigrants. With germ diseases removed from the purview of the Public Health Service officer at Ellis Island, a subtle shift occurred. Democratization of medicine by the germ theory, by which the immense gulf between physicians and poor patients during the 19th century shrank to a thin film during the 20th, had no effect at Ellis Island. Hereditarian judgments which could flourish only outside the boundaries of the germ theory were based in accidental and irrelevant hostilities between state and federal officials in New York during the 1890s.

Removal of infectious diseases from Public Health Service jurisdiction at Ellis Island seemed at first to reduce medical inspection to a legal fiction.[23] Immigration statistics reflect the uncertainty of both surgeons and the Bureau of Immigration as to the medical department's function. Deportations based on medical certificates accounted for fewer than 2% of the total debarred (and, during most years, less than 1%) before 1898.[24]

Marine Hospital Service surgeons contented themselves with identifying idiocy, insanity, and pregnancy. They also certified to immigration inspectors defects which might lead an immigrant to become a public charge. "They

look at those persons as they pass,'' described one visiting physician in 1893:

> If a man has a hand done up, or any physical injury in any way, if a woman has a child that looks sick, or if a person has but one leg or one arm, or one eye, or there is any physical or mental defect, if the person seems unsteady and in any way physically incapacitated to earn his livelihood, he is passed to one side to be examined later.[25]

By 1893 the line inspection was well established as the best way for two doctors to examine 2,000 to 5,000 immigrants in a single day. Like immigration legislation, the line remained basically unchanged from its inception until the 1920s, when changes in immigration laws and internal developments in medicine, acting independently, made it unacceptable.

Use of Ellis Island as a training ground for young officers began in 1897 and coincided with new seriousness on the part of the medical department.[26] In 1898 medical examination of cabin passengers on shipboard was instituted, and trachoma was certified as a dangerous, contagious disease. Medical deportations rose sharply: rejection on the grounds of ''dangerous, contagious'' rose from a single deportation during 1897 to 258 in 1898. Expressed differently, the percentage of all deportations based on the dangerous, contagious clause jumped from 0.5% in 1897 to 8.8% in 1898.

Classification of trachoma as a dangerous, contagious disease marked the first of the ''immigrant diseases,'' which somehow existed outside the continuum created by the germ theory in which physician and patient were equally vulnerable. Immigrant diseases—trachoma, favus, ringworm, and, to a lesser extent, tuberculosis, syphilis, and gonorrhea—were viewed as symbols of the immigrants' low condition, greater susceptibility to disease, and congenital ignorance of hygiene. ''They live on a low plane,'' wrote a Public Health Service officer in 1913. ''Overcrowding, disregard of privacy, cleanliness and authority, their gregariousness and tendency to congestion along racial lines in cities, are all important factors in the spread of disease among them and by them.''[27]

The Surgeon General's annual reports may have resounded with the names of medical officers struck down by typhus, cholera, or yellow fever, but, as one outside physician pointed out in 1911, no Ellis Island physician ever came down with trachoma in spite of constant contact with such cases.[28]

With the labelling of a group of diseases for all practical purposes limited to immigrants, medicine at Ellis Island implicitly endorsed a perception of immigrants as constitutionally different. ''Trachoma,'' wrote a Public Health Service officer in a 1907 pamphlet, ''is essentially an imported disease, apparently does not originate de novo in any area, and its presence in such

areas can nearly always be traced to cases which have originated from without." The pamphlet went on to speculate that the increasing prevalence of trachoma in the United States was most likely due to "the change in the source of arriving immigrants and resulting difference in the character of the people."[29]

Emphasis on detection of trachoma was praised by the Commissioner General of Immigration, T. V. Powderly, in 1902 as "virtually a new departure in the work of the Immigration Bureau ... in detecting and excluding contagious disease the nature of which less is known outside the medical profession than of the more generally recognized and easily detected forms of contagion."[30]

This new departure of the Public Health Service physicians had two important effects. By certification of trachoma as dangerous and contagious, physicians redefined a disease as dangerous not if it threatened life but if it impaired the usefulness of the sufferer.[31] "The object is not only to prevent the introduction into this country of a communicable disease," wrote the author of the 1903 *Handbook of the Medical Examination of Immigrants*, "but also to keep out a class of persons from whom so large a proportion of the inmates of institutions for the blind and recipients of public dispensary charity are recruited."[32]

By change in the definition of dangerous, contagious disease, physicians tacitly acknowledged a shift in emphasis of America's reception of immigrants. Until the 1890s, legislation aimed to protect immigrants and laws relative to immigration stipulated such protective measures as the minimum space in steerage allowable per passenger. By the end of the 19th century, however, it was clear that the emphasis had changed, and it was the United States which was to be protected.[33]

But, most important, the new classification of trachoma reflected a subtle change in the public's perception of medicine: removing detection of disease from the competency of lay observers. To the original framers of immigration legislation of the 1890s, the great advantage of laws barring the entry of physically defective aliens was the obvious visibility of disease: "Vice may come in the cabin or the steerage, in rags or fine raiment, and escape detection, but ... diseases ... proclaim their presence and are their own detectors."[34]

Medicine was not appealed to because of its prestige, but because it had jurisdiction over what anyone could see: illness. Adherents of medical freedom fought their battles on the grounds of therapeutics, but scientific medi-

cine's eventual victory rested on epistemologic grounds: not who would treat, but who would define health and disease: "In the modern world it is medicine's view of illness that is officially sanctioned and, on occasion, administratively imposed on the layman ... the judge determines what is legal and who is guilty, the priest what is holy and who is profane, the physician what is normal and who is sick."[35]

The ascendancy of medicine in America was marked by increasing use of illness as "the ubiquitous label for deviance." With the line physician stationed at what one English immigrant described as "the nearest earthly likeness to the Final Day of Judgment," Ellis Island was medicine's object lesson of the consequences of expansion.[36]

Medical inspection at Ellis Island gradually increased in stringency in response both to public sentiment toward immigration and public sophistication about medicine. Line inspection was not to establish diagnosis, but to detect abnormalities.[37] After 1898 eversion of the eyelid to detect trachoma was done on any immigrant with signs of corneal roughness or opacity, thickened or drooping lids, or conjunctival congestion.[38] But by 1905 increasing stringency of the medical examination required *all* immigrants to have their eyelids everted, and photographs of the line inspection usually show this final and most irksome part of the medical inspection. By 1913 all medical officers were expected to acquaint themselves with the rudiments of half a dozen foreign languages to assess the mental status of immigrants on the line. By 1917 palpation of the groins of all male immigrants and assessment of pupillary light reflexes to detect syphilis were included in the line inspection.

Once the alien was turned aside, the examiner theoretically had as much time "as may be necessary to ensure a correct diagnosis." Physical examination of immigrants "off the line" focused on the point which had aroused the suspicion of the line physician, but examination was to be "sufficiently thorough ... to determine whether there are other defects besides those which primarily attracted attention." Auscultation of the heart and examination of the optic fundi were routine by 1903.[39] The percentage of immigrants certified for disease or defect predictably rose from 0.77% in 1898, to 1.26% in 1909, to 2.78% in 1912.

The number of physicians assigned to the medical inspection also, of necessity, increased. From 1891 to 1898 two medical officers inspected 2,000 to 5,000 immigrants daily. In 1902 the number was increased to four officers on two separate lines. In 1910 seven officers were assigned to this

duty, and in 1914 11 officers manned four lines. Additional medical officers were assigned to Ellis Island to examine second-class passengers on shipboard (the Boarding Division), and to care for acutely ill immigrants at the Ellis Island Hospital (the Hospital Division).

A diagnostic laboratory was in operation by 1896, and made possible bacteriologic diagnosis of tuberculosis from sputum and identification of various fungi. Urinalysis was done by 1900. After 1910 syphilis was documented by Wassermann tests and by 1916 the Ellis Island laboratory routinely prepared vaccines, and analysed urine, sputum, throat cultures, stool, and cerebrospinal fluid.[40] Cultures and complete blood counts were done, as were vaginal smears for gonorrhea, the last made possible by the addition of two women acting assistant surgeons to the medical department in 1914.[41]

Immigration work was considered a hardship post in the Public Health Service, one reason why between 1897 and 1914 young officers had Ellis Island as a first tour of duty. Hours were long, and officers frequently worked a seven-day week. Line physicians, on their feet hours at a time, were under continual physical and mental strain. Breakdowns were common. Letters from Ellis Island to the Bureau during the period between 1900 and 1910 are a continual plea for more officers to augment a perennially inadequate force. "The existing force is so frequently reduced by reason of absence of one or another on account of illness," wrote Dr. G. W. Stoner, chief medical officer in 1903, "that it is impossible to meet the requirements of the Immigration Service with the present number of officers."[42]

For a young medical officer, thrown on the line after a few brief words of instruction, there was always the possibility that immigrants he passed as sound on primary inspection would be sent back to the medical department by a sharp-eyed registry clerk upstairs: "An old experienced immigration officer can tell in less than two days whether the newly arrived medical officer knows his business or not."[43] Dr. Stoner estimated that it took at least 30 days of continuous duty on the line for a medical officer to be of any use. Dr. Safford, another Public Health Service officer, disagreed: he thought about one year of special training was necessary.[44]

Old line officers who had been at Ellis Island for years developed an astonishing facility for detecting disease, and at times could diagnose occult illness at a glance. A young officer, S. B. Grubbs, later recalled his first attempts at "snapshot diagnosis":

> I wanted to acquire this magical intuition but found there were few rules. Even the keenest of these medical detectives did not know just why they suspected at a glance

> a handicap which later might require a week to prove .... Deep lines about the mouth seemed to go with hernia, drooping eyelids pointed to trachoma, or something like it, a certain pallor called for a careful examination of the heart, and the glint of eyes suggested tuberculosis.[45]

Medical inspection at Ellis Island was publicly acknowledged by both the Public Health Service and outside physicians as a forward step in medicine's rightful place as arbiter of moral and social values. "The medical phases of immigration blend very quickly into the subjects of national health protection, national eugenics and even the future existence of the ideals and standard of life which we are proud to call American," wrote a Public Health Service officer in 1912. He continued, "No one is better qualified than the physician to say which immigrants are desirable."[46] The president of the New York City Board of Health agreed: "A certificate of physical deficiency issued by an examining surgeon should be considered final reason for deportation, with no right of appeal except before a board of surgeons, and then only on the ground of an error in diagnosis."[47]

But in spite of the doctors' ambitions, medicine was never to enter into its claim of impartial power at Ellis Island. Despite frequent public references by the Bureau of Immigration to the important work of physicians, conditions under which the medical department worked clearly revealed that the emphasis of the immigration inspection was not on the physicians of the Public Health Service, but on the inspectors of the Immigration Bureau, hunched over their manifest lists in Ellis Island's great hall.[48] Quarters for the medical division were cramped, noisy, poorly lit, and badly ventilated. It was virtually impossible to listen for heart sounds in a place which was never quiet.[49]

In addition to unsatisfactory physical conditions, officers had to resign themselves to compromise of technical control over their work. A totally impartial inspection "would cause an intolerable annoyance to regular commerce and travel." On days when immigration was heavy, it was understood that fewer immigrants were to be turned off the line. "The medical officer . . . ," advised the 1903 *Handbook*, "shall conduct the medical inspection in such manner as to expedite ... the work of landing immigrants." Officers could be more stringent on days when incoming ships were few. "When it becomes necessary to detain [immigrants] for further examination for one or more days," wrote an Ellis Island officer in 1912, in a letter marked "Personal and Confidential" to the Surgeon General, "we are badly clogged and the Immigration Service is correspondingly annoyed."[50]

All immigrants certified by the Public Health Service doctors automatically became cases for the Board of Special Inquiry, a group of three immigration officers appointed by the Commissioner of Immigration. Boards of Special Inquiry decided all cases of immigrants not "clearly and beyond a doubt entitled to land." By placing medical certificates under scrutiny of a group of nonphysicians, the immigration law set a precedent that has bothered physicians ever since: lay review of medical decisions.

The effect of lay decisions on medical certificates was nowhere demonstrated so well as at Ellis Island. Boards of Special Inquiry admitted most immigrants certified as defective or diseased. In 1892 87% of those immigrants certified by the doctors were eventually landed, and in 1902 64% of those certified were landed.[51]

Writing from the Barge Office in July 1897, a few weeks after a fire on Ellis Island had burned all buildings and records, a harried Marine Hospital Service officer informed the Surgeon General, "The Board of Special Inquiry ... decides whether or not a case certified by the Examining Surgeon shall land or be deported . . . this action extending to all certificates whatever, whether covering cases whose exclusion is mandatory or only advisable.[52] He continued in another letter written on the same day to a friend and fellow officer:

> I am very sorry indeed that our records are all gone, for we could have furnished a long and interesting list of overrulings.
>
> I do not wish to be factious, but you must know that it is rather unpleasant to have a board of laymen undertake to correct a professional opinion. It is rather discouraging to do careful exclusion of undesirable people and then have them admitted.[53]

In 1911 the interior of the Ellis Island station was extensively renovated and the medical department moved to enlarged and improved quarters on the ground floor. Medical inspection became more efficient and thorough and led to an increased number of certifications. Greater stringency of medical inspection was reflected by a sharp rise in overrulings: In 1912 79% of all those certified were landed. The Board of Special Inquiry did not feel a need to increase its stringency in the face of an increasing strictness on the part of the doctors.

Though physicians were unhappy about overrulings, deportations based on medical certification very definitely rose over the years. In 1898, the first year in which trachoma was declared "dangerous, contagious," deportations on medical certification (which included degenerative disease, valvular heart disease, blindness, and hernia) accounted for 18% of the

total. In 1908 38% of all deportations were for medical reasons, and in 1916 69%.

Ellis Island physicians at first concentrated on infectious diseases, but the 1907 immigration law empowered physicians to state on a medical certificate whether a defect would likely lead the immigrant to become a public charge. The new law was favored by immigration restrictionists, confident that more "likely to become a public charge" deportations would result were they backed by medical certification. "The law has many possibilities which have not yet been fully developed," wrote William Williams, a Commissioner at Ellis Island in 1913, "and there is no portion of it which furnishes so fertile and at the same time rational a field for development as that which deals with the exclusion of immigrants who are mentally and physically defective."[54] However, delegation of such power to physicians was never realized in fact. Most Board of Special Inquiry overrulings were made on "likely to become a public charge" certificates. It seemed obvious, to some laymen at least, that prediction of the likelihood that a person would become a public charge was not a job for physicians. As a lawyer wrote to the chairman of the Dillingham Committee:[55]

> The certificate provided for goes beyond professional medical opinion. It covers the existence of a defect which "may affect the ability of the immigrant to earn a living," a question of business and common sense in which a layman's opinion is as good, if not perhaps better than that of a medical officer."[56]

With respect to infectious disease, physicians' certificates had more influence, but even purely medical certificates were at times overturned. In 1910 9% of all immigrants certified as having a "dangerous, contagious disease" were landed. At the outbreak of World War I the difficulty of returning diseased immigrants to Europe resulted in increased admission of those with "mandatorily excludable" conditions. With cessation of hostilities, the number of immigrants landed did not decrease to prewar proportions. The medical certificate's power to exclude was badly damaged.

Bureau of Immigration policy of overruling medical certificates seriously lowered the morale of Public Health Service officers at Ellis Island, but, despite their unhappiness, all complaints remained within the confidential letter files of the Public Health Service. The Service did not want to damage the prestige it was steadily accumulating outside of its immigration work in the control of infectious disease and in scientific research. The Bureau of Immigration had obvious reasons not to publicize a policy which, strictly viewed, was illegal. In 1917 a new immigration law made

medical certificates for "dangerous, contagious disease" binding on Boards of Special Inquiry, but in 1918 47% of all immigrants certified as having a dangerous, contagious disease were landed![57]

The Public Health Service had a somewhat inconsistent attitude toward immigration in response to the realities of duty at Ellis Island. Officers of the Service wrote on the importance of medical inspection, but in private were extremely wary to strike out in new directions. A transcript of a 1907 meeting of five Public Health Service officers, including Surgeon General Wyman, with the Secretary of Commerce and Labor, Oscar S. Straus,[58] shows that the physicians are not overly enthusiastic about putting "likely to become a public charge" on medical certificates. More significantly, they are unfavorable to the suggestion that a Public Health Service officer sit on the Board of Special Inquiry:

> Dr. G. W. Stoner. I want to suggest that the doctor just sit by as an advisor to the board.
>
> Dr. Taliaferro Clark. I think that the doctor, by having a vote on the board is in the nature of a retained attorney. He is interested in the exclusion of the immigrant, while if he is entirely unbiased by not having the power to vote, then he can give the facts without being influenced one way or the other.[59]

Public Health Service officers were also unhappy with attempts by lay members of the public to use the prestige of medicine for their own purposes. Prescott F. Hall, a founder of the Immigration Restriction League, wrote Surgeon General Wyman in 1908, "Those who are watching the effects of the immigration law are much interested in the working of the so-called 'poor physique' clause, and are anxious to get definite and correct figures as to its operation." [60] But Public Health Service physicians were not comfortable. "I believe the words 'poor physique' are very ambiguous," said Dr. Wyman at the 1907 conference, "and I am inclined to think that it would be wise to strike them out. Poor physique is not a diagnosis." Dr. Stoner at Ellis Island was equally troubled, as indicated in his statement, "The difficulty arises from the fact that the term does not imply a clinical or pathological entity."[61]

Some officers felt more strongly about immigration restriction than discretion permitted. One, A. C. Reed, resigned from the Service after writing a series of articles criticising medical inspection at Ellis Island: "The staff is too small and the administrative policy is passive, rather than aggressive, reactionary rather than progressive."[62] Medical officers at Ellis Island never attempted to spearhead any measures to restrict immigration. "The constant aim of those having the medical inspection in charge,"

wrote a Public Health Service officer in 1906, "has been to build upon practical rather than theoretical grounds."[63] For line officers, the sheer volume of work at Ellis Island left little energy to take the wide view: medical officers on the line did not discuss the immigration laws.[64]

But, in addition to the physical exhaustion of the work was the intrinsic reluctance of physicians to assume the additional role of judges, seen in the unwillingness of the medical officers to sit on the Board of Special Inquiry.[65] Medical officers tempered their articles on the medical aspects of immigration by insisting that a physician "merely transmits the results of his medical examination to the specified immigration officers, who determine whether or not the alien is legally admissible."[66] Clearly, physicians felt entitled to the prestige of power, but could not accept its responsibilities. In turn, overruling medical certificates by Boards of Special Inquiry demonstrated the reluctance of laymen to reduce all human decisions to the rigors of science.

"Does the country at large demand a higher standard of medical examination for arriving aliens? If so, what shall this standard be?" asked a Public Health Service officer at a meeting of the American Academy of Medicine in 1912. "I wish to say that the answer must rest entirely with the demands of the people."[67] Ellis Island physicians, whatever their personal opinions about immigration, were kept from action by their position in the middle of a bureaucracy (the Bureau of Immigration), answerable to an even larger bureaucracy (the United States government), ultimately answerable to the American people. And the American people could always be relied upon to swing to the side of sentiment in individual cases brought before them in the popular press: "I think those doctors could never have had children of their own, or they would have understood," wrote a lady in Philadelphia to Secretary of Labor Nagel in 1910, protesting the exclusion of a Russian boy on the medical grounds of "feeblemindedness."[68] As a Public Health Service officer shrewdly pointed out, the surreptitious landing of "mandatorily excludable" aliens "followed the discovery on the part of President Roosevelt himself that while it was good politics to have stringent immigration laws to point to, it was poor practical politics to enforce them impartially."[69]

For most officers, the primary job of the Public Health Service was not to be the cutting edge of immigration restriction. As an officer wrote years later:

> The Service scrapped its old name of a Marine Hospital Service and was officially designated as The Public Health Service. By the change it became, ex officio as it were, a presumptive benefit to mankind. It was thus better enabled to branch out in new directions and go into activities more favorable to the ambitions of those who were directing its affairs than in aiding in the enforcement of unpopular laws.

> Immigration laws must be characterized as unpopular. They may be endorsed in the abstract, but the public will always be found against their enforcement in concrete cases.[70]

Ellis Island was a maelstrom, and the best policy was to be above reproach, or at least to seem so to the public. Hence the Ellis Island Hospital was one of the best in the country, and assignment to the Hospital Division, as opposed to the Line Division, was considered a desirable post in the Service and was much sought after.[71]

Handbooks for medical inspection emphasized that immigrants should always be given the benefit of the doubt; a diagnosis of tuberculosis had to be documented by the tubercle bacillus in the sputum. At least two Wassermann reactions "with an interval of not less than two days" were needed to prove syphilis. Favus, a fungus infection of the scalp and nails, could not be certified without both clinical and microscopic evidence.[72]

> In view of the serious consequences, as our findings are frequently combatted at Ellis Island, at Washington and in court, and as all of our work is thus done in an atmosphere of hostility, we cannot afford to depend upon any single test, no matter how valuable, or to adopt a mode of procedure which would result in mechanically grinding out a diagnosis.[73]

The Public Health Service officer was also not unaware of the gravity of a medical certificate on the future of the immigrant involved:

> A certificate based on insufficient grounds means unnecessary and painful separation of families and the sending back of an alien to the ends of the earth regardless of the hardship involved .... An error which results in unjustly deporting an alien from New York to Eastern Europe is a grievous blunder and is without remedy.[74]

As the Public Health Service became more involved in epidemiology and public health programs, medical inspection at Ellis Island, already demoralized by Immigration Bureau policies, became somewhat of a dumping ground for the Service. After World War I, assignment to the line at Ellis Island could be interpreted as official displeasure; an older officer with no talent for scientific research, an unlucky officer who stumbled drunk into a hospital ward, an unnaturally taciturn officer whose commanding officer suggested transfer to a post which would "not bring him into close relationship with the public"—all ended up inspecting immigrants on the line. Medical interns at the Ellis Island Hospital during the early 1920s remembered Public Health Service officers there as either acting assistant surgeons or uninspired martinets; the talents of the Service were deployed elsewhere. "Without doubt, the Service has not in recent years given the proper attention to the immigration duties devolving upon us," wrote a Bureau officer to Dr. L. L. Williams in 1920, "but I do not feel as badly about the dereliction as I would were the

Immigration Bureau inclined to take more serious action upon our medical certificates.''[75]

But the Public Health Service had problems other than the Bureau of Immigration. By an irony of events, attacks on leniency at Ellis Island in admitting ''undesirable'' people focussed not on the Immigration Bureau, but on the line inspection. During the second decade of the 20th century, criticisms of the line inspection at Ellis Island by both outside physicians and laymen increased. In an additional irony, popular criticisms of the line inspection reflected the success with which the medical profession had indoctrinated the American public. The growth in the prestige of medicine was accompanied by expectations which demanded constant demonstrations of medicine's esoteric apparatus. The spectacle of thousands of immigrants moving past a figure in a military uniform (which reminded one lay observer in 1913 of ''the six o'clock rush past the ticket man on subway or elevated'')[76] did not satisfy the public's image of the physician.

By 1910 apologists for the line had to abandon statements characterising the examination as ''in reality searching and thorough.''[77] More sophisticated tacks were attempted. ''In these days of laboratory experimentation and the use of refined methods of diagnosis,'' wrote a Public Health Service officer in 1911, ''the value of simple inspection of the patient has gradually been lost sight of, and the art of snapshot diagnosis has been left almost entirely in the hands of the charlatan.[78]

Another officer in 1914 pointed out, ''It can be safely stated that almost no grave organic disease can have a hold on an individual without stamping some evidence of its presence upon the appearance of the patient evident to the eye or hand of the trained observer.''[79] The immigration laws of 1891, 1907, and 1917 did not change their conception of illness as ''external and difficult of concealment.'' What changed was the self-image of medicine and its practitioners. In the increasing complexity of science and society in the 20th century, the simplicities of the line, no matter how well they might have suited the purpose of the laws, did not fit into the social reality which both physicians and laymen came to consider medicine.

In 1891 dangerous, contagious diseases would be certified by Ellis Island physicians. By 1907 the question whether an immigrant was likely to become a public charge was put under the jurisdiction of the medical department. And by 1919 persons awaiting deportation at Ellis Island for ''anomalous social doctrines'' would be considered serious candidates for mental testing. Each step took medicine further away from infectious diseases and its initial

successes. Medicine at Ellis Island had expanded its boundaries, but had not become stronger or more influential: Boards of Special Inquiry continued to ignore most medical certificates. The list of excludable conditions lengthened, but advocates of immigration restriction began to realize that no list could ever be long enough.

In 1921, fueled by the postwar American revulsion at all things European, the first "quota" law was passed to limit immigration numerically solely by country of origin. "Desirable" countries with northern European populations, such as Germany and England, had large quotas. "Undesirable" eastern and southern European countries were granted small ones. In 1924 the number of southern Italians allowed to enter the United States barely equalled the number who came into Ellis Island on a single day in 1907.

The physicians of the Progressive Era, drunk from the successes of the epidemiologic and public health victories of the early 20th century, had to confront the lessons of Ellis Island doctors. The overrulings by the Bureau of Immigration symbolized lay reluctance to grant physicians a role as arbiters of moral values as well as medical judgments. Medicine, in spite of the ambitions of its partisans, would remain a *consulting* profession. After the optimism of the Progressive Era was annihilated by World War I, the boundaries physicians claimed shrank. But even when horizons seemed limitless, lay acceptance of how far medicine could go in defining the world were demonstrated in the unhappy experiences of the Ellis Island doctors during medicine's "heroic age."

REFERENCES AND NOTES

1. The Service was founded in 1798 as the United States Marine Hospital Service to care for American merchant seamen. In 1903, in recognition of its expansion into the wider areas of quarantine and infectious disease control, its name was changed to the United States Public Health and Marine Hospital Service. The Service was officially renamed the United States Public Health Service by Act of Congress in 1912. The Service will be referred to throughout this paper as the Public Health Service.
2. Only steerage passengers who were not American citizens were sent to Ellis Island. Beginning in 1898, second-class passengers were inspected by Public Health Service officers aboard ship, and any turned aside for acute illness or suspicion of disease or defect were also sent to Ellis Island. First-class passengers, mostly wealthy American tourists, were not examined, although occasionally an acutely ill first-class passenger was sent to the Ellis Island Hospital for treatment.
3. Sprague, E. K.: Medical inspection of immigrants. *Survey 30:*420-22, 1913.
4. The New York State immigration depot in New York City's Battery, Castle Garden, was so indelible a part of the folklore of European immigrants that long after Ellis Island had replaced it immigrants questioned as to where they were promptly replied "Castle Garden," and this would be counted as a correct answer. In the oral history collection at the

Statue of Liberty, one woman recalling her experiences at Ellis Island repeatedly refers to it as "Castle Garden," even after being corrected by the interviewer.
5. Bonner, T. N.: *American Doctors and German Universities*. Lincoln, Neb., University of Nebraska Press, 1963.
6. Waitzkin, H.: A Marxist view of medical care. *Ann. Int. Med. 89*:264-78, 1978.
7. Flexner, S. and Flexner, J.T .: *William Henry Welch and the Heroic Age of American Medicine*. New York, Viking, 1941, pp. 119, 478.
8. The Hygienic Laboratory was the direct forerunner of the present-day National Institutes of Health.
9. Stoner, G. W.: History of the Marine-Hospital Service. In: *1893 Annual Report of the Surgeon General*. Washington, D. C., Govt. Print. Off., 1893, p. 47.
10. Gunn, R. A.: *Everybody's Doctor: A New and Improved Handbook of Hygiene and Domestic Medicine*. New York, Dennis, 1885, p. 203.
11. Compulsory physical examination was not new to such captive populations as the military. The Federal Medical Corps between 1861 and 1865 performed and recorded over a million physical examinations of Union soldiers. The first compulsory medical inspection conducted on a civilian population was at Ellis Island.
12. For example, in New York City the compulsory notification of all pulmonary tuberculosis diagnosed in public institutions was instituted in 1893, but compulsory notification by private physicians was not effected until 1897, and then only with great difficulty. (Fox, D.: Social policy and city politics: Tuberculosis reporting in New York, 1889-1900. *Bull. Hist. Med., 49:*169-7, 1975.) Compulsory medical examination of school children in New York City began in 1905.
13. Winslow, C.-E. A.: *The Life of Herman M. Biggs*. Philadelphia, Lea and Febiger, 1929, p. 200.
14. Waserman, M.: The quest for a national health department in the progressive era. *Bull. Hist. Med. 49:*353-80, 1975.
15. *Annual Report of the Surgeon General*. Washington, D.C., Govt. Print. Off., 1892, p. 11.
16. Parsons, R.P.: *Trail to Light, a Biography of Joseph Goldberger*. New York, Bobbs-Merrill, 1943, p. 111.
17. Ward, R. deC.: Pending immigration bills. *North Am. Rev. 183:*1120-33, 1906.
18. Highham, J.: *Strangers in the Land: Patterns of American Nativism 1860-1925*. New York, Atheneum, 1965, p. 88.
19. James, H.: *The American Scene*. New York, Scribners, 1946, p. 86.
20. Letter from J. B. Weber (Commissioner of Immigration) to L. Crounse, Assistant Secretary of the Treasury, November 28, 1891: "Incoming correspondence 1891-92" Box 95, Record Group 90 (Public Health Service files), National Archives.
21. The 1891 law regarding the medical inspection reads as follows: "The medical examination shall be made by surgeons of the Marine Hospital Service." The Service at that time had four levels of officers: surgeon general, surgeon, passed assistant surgeon, and assistant surgeon. All physicians entered the corps as assistant surgeons.
22. *Annual Report of the Surgeon-General*. Washington, D. C., Govt. Print. Off., 1891, p. 18.
23. Safford, V.: *Immigration Problems, Personal Experiences of an Official*. New York, Dodd Mead, 1925, p. 19.
24. The initial spurt of medical deportations in 1892 and 1893 of 4.7% and 8.7%, respectively, cannot be accounted for by any reasonable explanation that comes to light. Such flukes must be laid to the standard pat answer in dealing with immigration statistics, that is, "variations in administrative interpretation of the law."
25. Wingate, U. O. B.: Quarantine immigration at the Port of New York. *Milwaukee Med. J. 1*:181, 1893.
26. Letter from J. H. White to Surgeon General Wyman, January 21, 1897. File 219 Box 36, RG 90, National Archives.
27. Reed, A. C.: Immigration and the public

health. *Pop. Sci. Monthly 83:*320-38, 1913.
28. Statement of Dr. Alfred H. Riedel, hearings on House Resolution ... May 29, 1911. William Williams papers, New York Public Library, Box 4.
29. Clark, T. and Schereschewsky, J. W.: *Trachoma: Its Character and Effects.* Washington, D.C., Govt. Print. Off., 1910 (PHS Bulletin No. 19).
30. Powderly, T.V.: Immigration's menace to the public health. *North Am. Rev. 175:*53-60, 1902.
31. Letter from G. W. Stoner to Surgeon General Wyman, October 21, 1897. File 219, Box 36, RG 90, National Archives.
32. *Handbook of the Medical Examination of Immigrants,* Washington, D.C., Govt. Print. Off., 1903, p. 7.
33. As late as 1894, a Public Health Service officer attending a medical conference in Europe stopped on his way back to inspect lodgings for immigrants waiting embarkation to America. "At the time of my visit there were some 30 or 40 immigrants housed in the building," wrote Dr. H. W. Austin to the Surgeon General, "they were furnished with proper food, comfortable beds, and were generally well cared for." (*Surgeon General Annual Report 1894,* p. 15) Throughout the immigration period, concern with the comfort of immigrants under the care of the medical department at Ellis Island was considered paramount by the Public Health Service because it reflected on the reputation of the commissioned corps.
34. Powderly, op. cit., pp. 53-60.
35. Friedson. E.: *Profession of Medicine.* New York, Dodd, Mead, 1970, p. 244.
36. Graham, S.: *With Poor Immigrants to America.* New York, Macmillan, 1914.
37. *Handbook* 1903, p. 6.
38. *Handbook* 1903, p. 7.
39. *Handbook* 1903, p. 13; *Handbook of the Medical Examination of Immigrants,* Washington, D. C., Govt. Print. Off., 1917, p. 17.
40. *Annual report of the Surgeon General.* Washington, D. C., Govt. Print. Off., 1916, p. 216.
41. Acting assistant surgeons were civil service physicians assigned by the Public Health Service to routine tasks thought not to require the expertise or prestige of an officer of the commissioned corps. The appointment of Dr. Rose A. Bebb as the first Ellis Island woman physician was noted in the Surgeon General's Annual Report of 1914: "For obvious reasons this measure has resulted in rendering practicable a more critical inspection of women immigrants turned aside for further medical examination and is regarded as making for increased efficiency." (p. 210) The ignorance of many European immigrants made any gynecological examination a risky procedure, and the 1910 *Handbook* cautioned medical officers "not to undertake the physical examination of a female alien, whether for pregnancy or otherwise, except in the presence of a third person." (p. 20)
42. Letter from G. W. Stoner to Surgeon General, December 21, 1901. File 2855, Box 258, RG 90, National Archives.
43. Safford, op. cit., p. 274.
44. Letter from G. W. Stoner to Surgeon General, June 23, 1903. File 2855 Box 258, RG 90, National Archives; Safford, ibid., p. 251.
45. Grubbs, S. B.: *By Order of the Surgeon General.* Greenfield, Ind., Mitchell, 1943, p. 72. The 1917 handbook for the medical inspection of aliens listed the following conditions which could be detected on the line: "anurism, acromegaly, anemia, arteriosclerosis, arthritis, asthma, beriberi, Bright's disease, bronchitis, bunions, bulbar paralysis, cancer, chorea, choroiditis, deafness, diabetes, dysentery, emphysema, enteroptosis, exopthalmic goiter, favus of scalp and nails, filariasis, flat feet, Friedreich's ataxia, gallstones, gastric ulcer, glosso-labio-laryngeal paralysis, gonorrhea, guinea-worm disease, Hodgkin's disease, hysteria, ichthyosis, poliomyelitis, spastic paraplegias, leprosy, leukemia, locomotor ataxia, malaria, miliary tuberculosis, multiple neuritis, myxedema, neurasthenia, optic atrophy, pleurisy,

pellagra, progressive muscular atrophy, poor physical development, psoriasis, pulmonary tuberculosis, paralysis agitans, psychoses of various kinds, mental deficiency, sarcoma, scabies, sciatica, scurvy, spinal curvature, syphilis, tapeworm, uncinariasis, valvular disease of the heart, and varicose veins." (p. 19) Of course, not all of these conditions could be classed as deportable.

46. Reed, A. C.: The medical side of immigration. *Pop. Sci. Monthly 80:*383-92, 1912; Scientific medical inspection at Ellis Island. *Med. Rev. Rev. 18:*541-44, 1912.
47. Darlington, T.: Medico-economic aspect of the immigration problem. *North Am. Rev. 183:*1262-71, 1906.
48. As a Public Health Service physician pointed out in 1905: "At the Port of New York there is one Commissioner, one Assistant Commissioner, one superintendent, three boards of inquiry, about 75 inspectors and 300 clerks, interpreters, matrons and other employees, exclusive of the officers and attendants of the Medical Division and Immigration Hospital." (Stoner, G. W.: *The Medical News.* June 10, 1905.) At this time, there were four medical officers on the line.
49. Reed, A. C.: The relation of Ellis Island to the public health. *New York Med. J. 98:*172-75, 1913; Mernin, M.T .: Medical inspection of aliens at Ellis Island with special reference to the examination of women and children. *Med. Woman's J. 31:*172-75, 1924.
50. *Handbook 1903,* p. 15; *Annual Report of the Surgeon General 1905.* p. 133; Letter from E. K. Sprague to Surgeon General Blue, May 31, 1912. File 2855 Box 258, RG 90, National Archives.
51. The intractibility of immigration statistics to close analysis is due in part to the inconsistencies of both the Bureau of Immigration and the Public Health Service in tabulation from year to year. For example, though the Commissioner of Immigration began its Annual Reports in 1891 by listing reasons for deportation by port (Ellis Island was the principal port of entry, but immigration stations were located all along the Atlantic coastline), after a few years it dropped this form and thereafter only tabulated reasons for deportation for all ports combined. Unfortunately, the Surgeon General only tabulated reasons for deportation based on medical certificates for the Ellis Island station. The Surgeon General reports are especially inconsistent on reporting on the Public Health Service's immigration work, some years supplying the barest figures in a single paragraph, and other years printing elaborate statistical tables extending over many pages. The percentages quoted in the text are calculated principally from the Annual Reports of the Surgeon General.
52. Letter from J. H. White to Surgeon General Wyman, July 18, 1897. File 219 Box 36, RG 90, National Archives.
53. Letter from J. H. White to P. H. Bailhache, July 18, 1897. File 219, Box 36, RG 90, National Archives.
54. Letter from William Williams to Commissioner General of Immigration, March 31, 1913, File 219 Box 37. RG 90, National Archives.
55. The U. S. Immigration Commission, headed by Senator William P. Dillingham, a moderate restrictionist, was commissioned by Congress in 1907 to investigate the whole subject of immigration. In 1911 it published the famous (and voluminous) Dillingham Report, and appended a summary with a strong restrictionist bias.
56. Letter from Nathan Bijur to Senator William P. Dillingham, February 9, 1907. Oscar S. Straus papers, Box 5, Library of Congress.
57. Even today, standard histories of immigration give the impression that all immigrants certified by the doctors were deported. Indeed, it was and is part of the Ellis Island myth that one was not allowed into America unless "perfect." (Taped interview with Pearl Libow by the author, now at the oral history collection, Statue of Liberty, New York Harbor.)
58. Oscar S. Straus, a Theodore Roosevelt appointee, was Secretary of Commerce and Labor from 1906-1909. The first

Jew appointed to the cabinet, he predictably favored a liberal immigration law.

59. Conference of Public Health Service officers with Oscar S. Straus, February 8, 1907. Immigration and Naturalization Service Files, Record Group 85, INS 51490/19, National Archives.
60. Letter from Prescott F. Hall to Surgeon General Wyman, March 30, 1908. File 219 Box 36, RG 90, National Archives.
61. Letter from G. W. Stoner to Commissioner General of Immigration, March 30, 1906. File 219 Box 36, RG 90, National Archives.
62. Reed, A. C.: The relation of Ellis Island to the public health. *New York Med. J. 98:*172-75, 1913.
63. Heiser, V.: Immigration. *Am. Med. 1:*89-93, 1906.
64. The statement that the medical officers on the "line" did not talk about the immigration laws among themselves is gleaned from interviews conducted by the author of the surviving doctors who served at Ellis Island from 1912 to 1924. Even without this corroboration, however, the lack of interest in the wider implications of their work makes psychological sense. As George Orwell pointed out more than once (about another kind of front line), "People forget that a soldier anywhere near the front line is usually too hungry, or frightened, or cold, or above all, too tired to bother about the political origins of the war." *The Collected Essays, Journals and Letters of George Orwell.* New York, Harcourt, Brace, Jovanovich 1968, vol. 2, p. 250. Though life on the "line" was not as hard as being in the trenches, the work was difficult and taxing and the older officers complained about it constantly. (Interview with Grover Kempf, September 10, 1977, Tucson, Ariz.; interview with T. B. H. Anderson, September 22, 1977, Monroe, Va.).
65. The grandson of Dr. L. L. Williams, chief medical officer at Ellis Island from 1913 to 1918, recalled, "He [Dr. Williams] was a very warm and friendly person, and as a physician, consistently wanted to think of himself as a friend and helper to his patients, not as a judge. But the Ellis Island job put him in the latter relationship, even if only with respect to 'Medical Certificates'. He told me that he often felt torn between his sympathy for a family who had spent everything they had to come to the U.S., and his duty to uphold the laws of the U. S. He told me that he found it easier if he left the examinations and the personal contacts to others . . . . He and the "Board" would then make the decisions based on the medical findings in the records, but without really knowing the patients personally. Sometimes members of the Board had to see or examine patients themselves, and, of course language barriers mitigated somewhat the emotional impact." Letter from Dr. Charles L. Williams, Jr., to the author, November 9, 1977.
66. Safford, op. cit., p. 194.
67. Cofer, L.E.: Paper on immigration. In: *Medical Problems of Immigration.* New York, Am. Acad. Med., 1913.
68. Letter from Susanna Kitson to Secretary of Labor Nagel, *re* case of Benjamin Pocwiza's son, August 4, 1910. William Williams papers, New York Public Library.
69. Safford, op. cit., p. 88.
70. Safford, ibid., p. 260.
71. Interview with Dr. T. B. H. Anderson. Ellis Island was under constant scrutiny by both the public and its elected officials. "As you know I have always considered Ellis Island the most important station in the Service," wrote Surgeon General Cumming to a fellow officer in 1923, "not only on account of its size and the number of officers serving there and the magnitude of the hospital operations, but on account of its relationship toward the public and the Immigration Service." The conspicuousness of the Public Health Service at Ellis Island necessitated a constant display of its probity and competence to the public. (Cumming papers, U. of Virginia, Box 13. Letter from Cumming to C. H. Lavinder, December 19, 1923.)
72. *Handbook 1903,* p. 8; *Handbook 1917,* p. 37.
73. Williams, L. L.: The medical examina-

tion of mentally defective aliens. *Am. J. Insanity 71:*257-68, 1914.
74. L. L. Williams, ibid., pp. 257-68.
75. Interviews with Dr. Grover A. Kempf, Tucson, Ariz., September 10, 1977, Dr. T. B. H. Anderson; Confidential letter from L. L. Williams to Surgeon General Blue, July 11, 1914 (re Dr. J. J. Loughran). File 2855 Box 258, RG 90, NA; Letter from Victor Heiser to Surgeon General Blue, February 21, 1914 (re Dr. D.C. Turnipseed). File 3308 Box 290, RG 90, NA; interviews with Dr. Bernard Notes, Washington D.C., September 4, 1977, Dr. John C. Thill, Tampa, Fla., September 13, 1977; Letter from Assistant Surgeon General R. H. Creel to Dr. L. L. Williams, March 26, 1920. File 219 Box 38, RG 90, NA.
76. Eberle, L.: Where immigration medical inspection fails. *Colliers 50:*27, 1913.
77. *Annual Report of the Surgeon General 1906,* p. 60-61.
78. Wilson, J. G.: Diagnosis by inspection. *New York Med. J.,* 94-96, July 8, 1911. 1911.
79. Nute, A. J.: Medical inspection of immigrants. *Boston Med. Surg. J. 170:*642-46, 1914.

All taped interviews with physicians cited in the references have been deposited in the oral history collections of the Statue of Liberty, New York Harbor, and the National Library of Medicine, Bethesda, Md.